



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

University Medical Center

Respondent Name

Lubbock County

MFDR Tracking Number

M4-17-0137-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

September 19, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a 1 day inpatient stay that should pay per DRG. The total reimbursement should be \$32739.31. DRG rate \$22894.62 x 143% = \$32739.31. Carrier has paid \$26590.04 leaving a balance due of \$6147.27."

Amount in Dispute: \$6,149.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of an acknowledgement of receipt of the medical fee dispute resolution on September 26, 2016. Texas Administrative Code §133.307 (d) (1) states, "Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division. (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." As no response was received this dispute will be reviewed based on available information.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6 – 11, 2015	Inpatient Hospital Services	\$6,149.27	\$6,123.68

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – The benefit for this service is included in the pymt/allowance for another service/procedure that has already been adjudicated
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment
 - 96 – Non-covered charge(s)
 - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
 - W3 – Additional payment made on appeal/reconsideration

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking \$6,149.27 for services rendered between October 6 through 11, 2015. The insurance carrier reduced the disputed services with claim adjustment reason code P12 – “Workers’ compensation jurisdictional fee schedule adjustment.”

This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. Reimbursement is therefore subject to the provisions of 28 Texas Administrative Code §134.404(f), which states that:

The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

- (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
 - (A) 143 percent; unless
 - (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason, the MAR is calculated according to §134.404(f)(1)(A).

2. Per §134.404(f)(1)(A), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Review of the submitted documentation finds that the DRG code assigned to the services in dispute is 515. The services were provided at University Medical Center. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount is \$22,876.73. This amount multiplied by 143% results in a MAR of \$32,713.72.
3. The total recommended payment for the services in dispute is \$32,713.72. This amount less the amount previously paid by the insurance carrier of \$26,590.04 leaves an amount due to the requestor of \$6,123.68. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$6,123.68.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$6,123.68 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	November 10, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.